

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013610

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3198

FILED MAR 28 1963

DO NOT WRITE ON THIS STUD

AMENDED

VS 300  
Rev. 4/59

DATE AMENDED

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28/20, 7

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>St. Clair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		Length of stay in 1b <b>10 days</b>	c. CITY OR TOWN <b>Summerfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>none</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Cornelia</b>		First <b>Cornelia</b>	Last <b>Monken</b>
5. SEX <b>female</b>		6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>household</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	8. DATE OF BIRTH <b>3/18/90</b>
13a. FATHER'S NAME <b>Phillip Perschbacher</b>		13b. MOTHER'S MAIDEN NAME <b>Rose Phoetner</b>	9. AGE (last birthday) <b>73</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		17. INFORMANT <b>Joseph V. Monken</b> Address <b>Summerfield, Ill.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage Subarachnoid Spont.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Aneurysm, int. carotid - not verified</b>			
DUE TO (c) <b>Arteriosclerosis cerebrovascular.</b>		<b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pneumonia, terminal 45/4</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>3-10-63</b> to <b>3-18-63</b> and last saw her alive on <b>3-17-63</b> Death occurred at <b>6:50 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>George E. Perschbacher M.D.</b>		22b. ADDRESS <b>3720 Woodlawn Ave St. Louis</b>	22c. DATE SIGNED <b>3-19-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>3/18/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Summerfield</b>	23d. LOCATION (City, town, or county) (State) <b>St. Clair County, Illinois</b>
24. FUNERAL DIRECTOR <b>L.M. Wolfersberger</b> ADDRESS <b>O'Fallon, Illinois</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 19 1963</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Frank Prokoff

Licensed Embalmer No. 4356

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.